NATIONAL ABORTION FEDERATION

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Dear Members of the Subcommittee on Select Revenue Measures of the Committee on Ways and Means:

I am writing regarding recent Congressional testimony for HR3, the "No Taxpayer Funds for Abortion Act" and HR 358, the "Protect Life Act." As an obstetrician-gynecologist with more than 20 years of experience providing both obstetric and complex abortion care, I wish to set the record straight.

I direct Northwestern University's Center for Family Planning & Contraception as well its academic Section of Family Planning. The medical center where I work performs nearly 13,000 deliveries annually. Most patients are healthy women having healthy babies, but I am frequently asked to provide abortions for women confronting severely troubled pregnancies or their own life-endangering health issues. Physicians who provide health care to women cannot choose to ignore the more tragic consequences of human pregnancy—and neither should Congress. The following portraits of the women I see illustrate just a few of the circumstances where abortion saves women's lives:

- One of my own obstetric patients carrying a desired pregnancy recently experienced rupture of the amniotic sac at 20 weeks gestation. The patient had a complete placenta previa, a condition where the afterbirth covers the opening to the uterus. Although the patient hoped the pregnancy might continue, she began contracting and suddenly hemorrhaged, losing nearly a liter of blood into her bed in a single gush. Had we not quickly intervened to terminate the pregnancy, she would have bled to death, just as women do in countries with limited access to obstetric services.

- My service frequently receives referrals from Northwestern's Division of Maternal Fetal Medicine and other high risk pregnancy services throughout the Chicago area. One of the more frequent reasons for referral is preterm rupture of membranes with chorioamnionitis, an intrauterine infection which can develop at any time during pregnancy. Since antibiotics will not sufficiently penetrate the endometrial cavity containing the baby, the treatment for this condition is to evacuate the uterus. If the infection occurs at term, we deliver the baby. If the condition occurs before 24 weeks, we must abort the pregnancy lest the patient become septic and die. Over my years of practice, I have had many patients who would have died without access to abortion in this situation.

- My service often receives consults regarding patients with serious medical issues complicating pregnancy. We recently had a 44-year-old patient whose pregnancy had been complicated by a variety of non-specific symptoms. A CT scan obtained

at 23 weeks gestation revealed that the patient had lung cancer that had metastasized to her brain, liver, and other organs. Her family confronted the difficult choice of terminating a desired pregnancy or continuing the pregnancy knowing that the physiologic burden of pregnancy and cancer might worsen her already poor prognosis. The family chose to proceed with pregnancy termination.

- My service often receives referrals regarding unusual obstetric conditions because we work at a tertiary care center. One complex condition referred to my service involved a patient who had a twin gestation in which one of the embryos was a molar pregnancy. Molar pregnancy is an abnormal pregnancy in which the embryo fails to develop—or develops partially—and the placenta develops into grape like tissue clusters. The abnormal placenta of molar gestation expands the uterine cavity and often causes severe hemorrhage. Patients are also more likely to develop a number of other medical problems during their pregnancy including intractable nausea and vomiting and early onset hypertensive disorders. Longer term, molar gestation places the patient at higher risk of developing choriocarcinoma, a cancer in which placenta-like material spreads throughout the body. Most molar gestations involve no embryo, but this patient had one normal twin and one molar gestation. Although she was only 22 weeks gestation, her uterus already approximated the size of a term pregnancy containing enough grape like clusters of placenta to fill a milk crate. We admitted the patient to the intensive care unit, obtained 10 units of blood in case severe bleeding occurred, and successfully terminated the pregnancy. By intervening when we did, we preserved the patient's life, her health, and her ability to have children in the future.

- My service sometimes sees patients who have received organ transplants or are awaiting transplants. I remember one woman in her early twenties who had end stage alcoholic cirrhosis of the liver. She had stopped using alcohol and successfully balanced school, work, and frequent hospitalizations to deal with her severe liver disease and related disorders. While awaiting a transplant, she conceived. She decided to terminate the pregnancy rather than accept the risks to her life and health posed by continued gestation. We have cared for other patients who chose to terminate while awaiting transplant or after undergoing transplant of heart, liver, and other organs. Although some of these patients might manage to continue pregnancies to term, each patient's circumstance is highly variable with unpredictable risk to life and health.

- A colleague on my team recently took care of another patient with leukemia. We have had many during my 15 years at Northwestern. Several years ago, we had three patients with leukemia requiring pregnancy terminations at approximately the same time. Because leukemia causes abnormal blood cells, patients with leukemia confront increased risk of both bleeding and infection. Pregnancy compounds these risks, particularly if they need to receive ongoing chemotherapy during the pregnancy.

- My service frequently sees patients with early pre-eclampsia, often referred to by the term “toxemia”. Pre-eclampsia usually complicates later gestation, but occasionally complicates pregnancy as early as 18 to 20 weeks, well before the fetus is viable. The only treatment for severe pre-eclampsia is delivery. Otherwise, the condition will worsen, exposing the mother to kidney failure, liver failure, stroke and death. One Christmas morning I had to leave my own family so that I could provide a pregnancy termination for a remarkably sick, pre-eclamptic teenager.

Patients like those described above rarely knew that pregnancy could jeopardize their lives and health. Some opposed “abortion”, even while they themselves were undergoing an abortion. Like most tertiary obstetric centers, we receive referrals of such patients from within our own system and throughout our metropolitan area. Some of the referrals come from providers or sectarian institutions that ostensibly oppose abortion, but rely upon us as the “safety valve” to assure that patients get care they need and deserve. We usually manage to intervene before a risk to health becomes a risk of life, but we do so because the law currently embraces patient and provider autonomy. What will obstetricians do when the law criminalizes interventions needed to save the lives of our daughters, wives, and mothers? Should health insurance only cover the cost of obstetrics when everything goes well—or should it also cover the cost of a standard obstetric procedure when the patient’s life and health is most at risk?

I hope our elected representatives will allow those of us who experience these circumstances on a regular basis to set the record straight—and prevent the passage of legislation that would harm women, families, and those who care for them.

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